

The Foster Care Independence Act of 1999: Enhancing Youth Access to Health Care

By Abigail English and Kathi Grasso

Each year as many as 20,000 young people age out of the foster care system.¹ Not only do most of them lack familial, financial, and other support, but also many of these young people have serious unmet physical and mental health needs. The poignancy of their situations and the impressive efforts they make with little support were illustrated at an October 1999 hearing that the Subcommittee on Health Care of the Senate Finance Committee of the U.S. Congress held on the Foster Care Independence Act. One witness, Terry Harrak, age 20, testified about her experience of being abandoned at 15 by her father and ending up in foster care. When she left foster care at 18, she was shown a film, given a “big” packet of information, and told “good-

bye.” As she explained, “[a] video and a packet does not prepare you for anything.” She spent time living on the street and sleeping in hospitals, “because they were safe and they were warm.” During this period she acquired numerous health problems—ringworm, chickenpox, body lice—and had no access to health care. She said that as difficult as she found it to testify about these personal matters in front of a roomful of strangers she was doing so “because I do not want anybody else to have to come up and tell my story and say, I was homeless, and I was denied Medicaid.”²

On December 14, 1999, President Clinton signed the Foster Care Independence Act into law.³ The Act has the potential to protect foster care youth from the

¹ U. S. GENERAL ACCOUNTING OFFICE, FOSTER CARE: EFFECTIVENESS OF INDEPENDENT LIVING SERVICES UNKNOWN (GAO/HEHS-00-13) 4 (Nov. 1999).

² *Health Needs of Children in the Foster Care System: Hearing on S. 1327 Before the Subcommittee on Health Care of the Senate Committee on Finance*, 106th Cong. 17 (1999) (statement of Terry Harrak, former foster care child, Annandale, Va.) [hereinafter statement of Terry Harrak].

³ Foster Care Independence Act of 1999, Pub. L. No. 106-169 (H.R. 3443), 113 Stat. 1822 (1999). The relevant provisions of the Act are contained in title I, sections 101-131. General responsibility for implementation of the Act at the federal level rests with the Administration on Children, Youth, and Families in the U.S. Department of Health and Human Services. During the first four months following the enactment of the Act, the Administration on Children, Youth, and Families issued two documents concerning its implementation. Administration on Children, Youth & Families, U.S. Dep’t of Health & Human Servs., Information Memorandum, ACYF-CB-IM-00-03 (Mar. 16, 2000) (informing states about the Act and forthcoming program instructions and about the formula for determining state funding allocations); Program Instruction, ACYF-CB-PI-00-04 (Apr. 20, 2000) (instructing states on how to apply for fiscal year 2000 funds under the Act) [hereinafter ACYF-CB-PI-00-04].

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anguish experienced by Terry Harrak. If fully implemented, it will enhance significantly the provision of transitional living services, including health care benefits, to young people moving out of foster care. It increases annual appropriations to the states for services, including housing, education, and employment assistance, from \$70 million to \$140 million.⁴ Most relevant to this article, the Act gives states the option of expanding Medicaid coverage to this population of young adults.⁵

Decisions of the federal government and the states over the next several months regarding the Act's implementation will influence whether youth exiting foster care have access to a full array of independent living services and Medicaid coverage. In this article we focus on those aspects of the Act that can facilitate improved access to comprehensive health care for youth making the transition out of foster care.⁶ First we give a background on the health status of youth in foster care and the problems typically encountered by those who have exited the child welfare system. Following that, we examine youth's need for comprehensive health services and the obstacles youth face in accessing health care. Next

we emphasize the importance of health insurance coverage, particularly Medicaid, and briefly review the scope of Medicaid eligibility (for youth who are in or aging out of foster care) before the Foster Care Independence Act was enacted. Finally we explain the health-related provisions of the Act and what states and advocates should do to ensure that they are effectively implemented.

I. Health Status of Children and Youth in Foster Care

Children and youth in foster care have long been characterized by intense health care needs, inadequate access to necessary health care, and poor outcomes as adults. Study findings indicate that a significant percentage of children and youth coming under the auspices of child welfare systems has or is at risk of having acute, chronic, disabling, and potentially life-threatening conditions. As evidenced by numerous class action lawsuits filed on behalf of children and youth in foster care over the past three decades, all too often these medical conditions are not prevented, identified, or treated.⁷ The health status of younger children as well as adolescents is relevant in evaluating the future needs of youth who leave fos-

⁴ The current appropriation for fiscal year 2000 is \$105 million. In his proposed fiscal year 2001 budget, President Clinton requested that Congress allot an additional \$35 million supplement to increase the fiscal year 2000 appropriation to the level stated in Section 101(a) of the Act (amending 42 U.S.C. § 677(h)). NATIONAL FOSTER CARE AWARENESS PROJECT, FREQUENTLY ASKED QUESTIONS ABOUT THE FOSTER CARE INDEPENDENCE ACT OF 1999 AND THE JOHN H. CHAFEE FOSTER CARE INDEPENDENCE PROGRAM 17 (Feb. 2000).

⁵ Foster Care Independence Act § 121, 113 Stat. 1822, 1829–30.

⁶ For a more general discussion of the Foster Care Independence Act's legislative history and its provisions, see Mary Lee Allen & Robin Nixon, *The Foster Care Independence Act and John H. Chafee Foster Care Independence Program: New Catalysts for Reform for Young People Aging Out of Foster Care*, in this issue.

⁷ See generally Deborah L. Shelton, *Who Turns in Uncle Sam for Child Abuse? Foster Kids Are Often Last in Line for Medical Services*, 22 HUM. RTS. 8 (Summer 1995); NATIONAL CTR. FOR YOUTH LAW, FOSTER CARE REFORM LITIGATION DOCKET (1998) (citing class action lawsuits addressing health care for children in foster care) (available from National Center for Youth Law, Oakland, Cal.); ELLEN SITTENFELD BATTISTELLI, *THE HEALTH CARE OF CHILDREN IN OUT-OF-HOME CARE: A SURVEY OF STATE CHILD WELFARE COMMISSIONERS 7-14 (1998)* (identifying barriers to appropriate health care services for children in foster care) (available from Child Welfare League of America, Washington, D.C.).

ter care because many children in foster care, especially those with serious health problems, remain in care until age 18.⁸

A. Physical, Developmental, and Sexual Health Concerns

A sampling of findings related to the physical, developmental, and sexual health concerns of selected populations follows:⁹

- Upon entry into the foster care system, 91.5 percent of children were found to have at least one abnormality in at least one body system. Approximately 39.2 percent of their health problems at initial consultations needed urgent referrals for medical services.¹⁰
- Fifty-three percent of foster children had one or more potential developmental problems. Children who were older and nonwhite when entering foster care with identified developmental problems were nearly twice as likely to remain involved with the foster care system.¹¹
- Forty-seven percent of adolescents in foster care were “handicapped.”¹²
- Of foster adolescents receiving a more comprehensive medical examination, 12.3 percent had tuberculin test positivity—a percentage “substantially higher than figures available for healthy adult populations, ranging from 2.5 percent among U.S. Navy recruits to 6.1 percent among applicants to a department of corrections.”¹³
- Among 15-year-old and older foster youth 86 percent reported being sexually active. Only 38 percent indicated regular contraceptive use, 38 percent believed that they were at risk of HIV (human immunodeficiency virus) or AIDS (acquired immune deficiency syndrome), 42 percent would like to have changed earlier decisions regarding sexual activity, and 26 percent had never spoken about sexual issues with adults with whom they had lived.¹⁴
- Seventeen percent of girls at the time of their discharge from foster care had experienced at least one pregnancy.¹⁵
- Seventeen percent had problems with drug abuse and 12 percent with alcohol abuse.¹⁶

⁸ See Mark E. Courtney and Richard P. Barth, *Pathways of Older Adolescents Out of Foster Care: Implications for Independent Living Services*, 41 SOC. WORK 75 (1996) (“Although the vast majority of children and youths [sic] entering foster care will return home to their families or be adopted, recent estimates suggest that as many as one of four will remain in care until late adolescence (Barth et al., 1994; Goerge, 1990), when they either ‘age out’ of the foster care system to more or less planned independent living or exit care by means of one of several less auspicious routes such as running away, being incarcerated, or entering a psychiatric hospital.”).

⁹ This statistical summary of the physical and mental health status of children and youth in foster care is adapted from one that appeared initially in KATHI GRASSO ET AL., A JUDGE’S GUIDE TO IMPROVING LEGAL REPRESENTATION OF CHILDREN 60-61 (1998).

¹⁰ Robin G. Chernoff et al., *Assessing the Health Status of Children Entering Foster Care*, 93 PEDIATRICS 594 (Apr. 1994).

¹¹ Sarah McCue Horwitz et al., *Impact of Developmental Problems on Young Children’s Exits from Foster Care*, 15 DEVELOPMENTAL & BEHAV. PEDIATRICS 105 (Apr. 1994).

¹² RONNA COOK ET AL., A NATIONAL EVALUATION OF TITLE IV-E FOSTER CARE INDEPENDENT LIVING PROGRAMS FOR YOUTH, PHASE 1, FINAL REPORT, VOLUME ONE 4-1(1990) (available from Westat Inc., Rockville, Md.).

¹³ John I. Takayama et al., *Relationship Between Reason for Placement and Medical Findings Among Children in Foster Care*, 101 PEDIATRICS 201 (Feb. 1998) (Tbl. 6: Medical Findings by Reason for Placement for Three Age Groups of Children Placed in Foster Care and Examined at the CPC in San Francisco, Cal., from Oct. 1, 1991, to Dec. 31, 1992).

¹⁴ BRONWYN MAYDEN, SEXUALITY EDUCATION FOR YOUTHS IN CARE: A STATE-BY-STATE SURVEY 4 (1996) (citing 1992 survey of youth in the custody of the Vermont Department of Social and Rehabilitative Services) (available from Child Welfare League of America, Washington, D.C.).

¹⁵ Cook et al., *supra* note 12.

¹⁶ *Id.*

B. Mental Health Concerns

In regard to mental health concerns, a sampling of findings for selected populations reveals the following:

- In foster care 22 percent of 3- to 6-year-old children, 63 percent of 7- to 12-year-old children, and 77 percent of teenagers were found to be in need of a mental health referral.¹⁷
- For foster children in California, 75 percent of mental health services billed under Medi-Cal, the state's Medicaid program, were for treatment of adjustment disorders (28.6 percent), conduct disorders (20.5 percent), anxiety disorders (13.8 percent), and emotional disorders (11.9 percent); and 12- to 17-year-old foster care youth accounted for 49 percent of all Medi-Cal eligible mental health service users.¹⁸
- Of the 77 percent of eligible foster children screened, 15 percent had indicated either a previous attempted suicide or were suspect for suicidal ideation, and 7 percent admitted to or were suspect for homicidal ideation;¹⁹
- Of 4- to 18- year-olds in foster care 48.7 percent showed evidence of psychological disorders; this population was 2 to over 32 times at higher risk of psychological disorders than children raised in their own homes.²⁰
- Thirty-eight percent of the adolescent foster care population were "emotionally disturbed."²¹

II. Health-Related Issues for Youth Aging Out of Foster Care

As young people age out of foster care, many of them continue to experience seri-

ous health problems. Because many have limited education or skills and lack adequate support, they experience a great deal of difficulty in securing necessary health care.

A. Negative Adult Outcomes and Health Care Access Problems

Lacking familial, governmental, and other support, young people exiting foster care are often ill equipped for the transition to young adulthood. The few outcome studies of these populations appear to support this proposition. Although several of the outcomes mentioned below (e.g., problems with economic self-sufficiency, minimal educational attainment) do not appear to relate directly to health care, they are important as they contribute to the high levels of poverty or low-income experienced by youth formerly in foster care. Poverty is associated both with negative indicators of health and well-being and limited access to health care.

According to Westat's 1990-91 study of 810 ex-foster youth in eight states, including New York, California, and Illinois, reporting on their experiences 2.5 to 4 years after exiting care, 46 percent did not have a high school diploma, 51 percent were unemployed, 40 percent were "a cost to the community," 30 percent had difficulty accessing health care due to inadequate finances and insurance, 60 percent of females had given birth, and 25 percent had experienced "problems with the law," the primary cause (51 percent) being drug and alcohol abuse.²² The study concluded that, "[w]ith respect to education completion, young parenthood, and the use of public assistance, discharged foster youth more closely resembled those 18 to 24 year olds living below

¹⁷ Chernoff et al., *supra* note 10.

¹⁸ Neal Halfon et al., *Mental Health Service Utilization by Children in Foster Care in California*, 89 PEDIATRICS 1238 (June 1992).

¹⁹ Chernoff et al., *supra* note 10.

²⁰ Anne McIntyre & Thomas Y. Keesler, *Psychological Disorders Among Foster Children*, 15 J. OF CLINICAL CHILD PSYCHOL. 297 (1986).

²¹ Cook et al., *supra* note 12.

²² RONNA J. COOK, A NATIONAL EVALUATION OF TITLE IV-E FOSTER CARE INDEPENDENT LIVING PROGRAMS FOR YOUTH, PHASE 2, FINAL REPORT, VOLUME ONE xiv-xvi, 4-24 to 4-25 (1992) (available from Westat Inc., Rockville, Md.).

the poverty level than they [did] 18 to 24 year olds in [the] general population.”²³ The study added that “[t]hese findings verify the need for services to help improve the outcomes for youth after discharge from foster care.”²⁴

Similarly a more recent study of 113 ex-foster children in Wisconsin 12 to 18 months after they left foster care revealed that 37 percent had not graduated from high school, 40 percent of females and 23 percent of males had received public assistance, 12 percent had experienced homelessness at least once, and 27 percent of males and 10 percent of females had been imprisoned at least once.²⁵ Regarding access to health care, 44 percent had encountered problems obtaining health care “most or all of the time,” with 51 percent stating the reason as lack of insurance coverage and 38 percent pointing to the cost of care.²⁶ Over 28 percent were unable to obtain dental care with 90 percent citing lack of insurance or cost of care being a barrier to these services.²⁷ Regarding mental health care, this study found that, “although the receipt of mental health services decreased dramatically over time, there is no evidence that the young adults’ need for services decreased.”²⁸ Other studies depict similar findings regarding educational, employment, housing stability, economic self-sufficiency, and incarceration rates.²⁹

A 1990 study of 55 former foster care recipients in the San Francisco Bay Area

and Sacramento concluded that “[f]ormer foster youth are vulnerable to serious health care problems.”³⁰ This study found that since exiting foster care 44 percent had experienced a “serious illness or accident,” with 24 percent requiring hospitalization (13 percent for an “emotional problem”).³¹ Although 62 percent indicated that they had “health or medical coverage at the time of the interview,” 40 percent stated that they “sometimes or often [had] problems or worries about medical bills” and 38 percent reported that they had a “current untreated health problem.”³²

When considering research findings from the late 1980s and early 1990s, we must keep in mind the impact of recent

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“welfare reform” on the receipt of public assistance, including public health insurance, by people with low incomes. Due to changes in eligibility criteria dictated by federal and state laws, many individuals and families are no longer eligible to receive general cash assistance benefits (formerly Aid to Families with Dependent

²³ *Id.* at xiv.

²⁴ *Id.*

²⁵ Mark E. Courtney & Irving Piliavin, University of Wis., *Foster Youth Transitions to Adulthood: Outcomes 12 to 18 Months After Leaving Out-of-Home Care* 1-16 (1998) <<http://polyglot.lss.wisc.edu/socwork/foster/index.html>>.

²⁶ *Id.* at 7-8.

²⁷ *Id.* at 8.

²⁸ *Id.* at 9.

²⁹ See Nan P. Roman & Phyllis B. Wolfe, *The Relationship Between Foster Care and Homelessness*, 55 PUB. WELFARE 4 (Jan. 1997); *Section 2: Outcome Studies of Foster Youths*, PREPARING FOSTER YOUTHS FOR ADULT LIVING: PROCEEDINGS OF AN INVITATIONAL RESEARCH CONFERENCE 7-26 (Edmund V. Mech & Joan R. Rycraft eds., 1995) (available from Child Welfare League of America, Washington, D.C.); Curtis McMillen & Jayne Tucker, *The Status of Older Adolescents at Exit from Out-of-Home Care*, 78 CHILD WELFARE 339 (May-June 1999).

³⁰ Richard P. Barth, *On Their Own: The Experiences of Youth After Foster Care* 7(5) CHILD & ADOLESCENT SOC. WORK 419, 426 (Oct. 1990).

³¹ *Id.*

³² *Id.*

Children, or AFDC, now Temporary Assistance for Needy Families, or TANF). Even though they may still be eligible for Medicaid or food stamps, they may not be receiving these benefits because of a misperception by both government personnel and themselves that they are not eligible because they are not eligible for general cash assistance. One recent study found that despite large, recent enrollment increases in State Children's Health Insurance Programs (CHIP), fewer children and youth were covered in 1999 than were covered in 1996: in the 12 states with the most uninsured children, fewer children were covered under CHIP and Medicaid in 1999 than were covered by Medicaid alone in 1996.³³ Another study also found sharp decreases attributable to welfare reform in the number of poor children covered by Medicaid.³⁴ In view of "welfare reform," youth exiting state custody will experience even greater difficulty in accessing health care and other benefits, especially if their unemployment and poverty rates remain high.

B. Lack of Adequate Transitional Living and Related Health Services

Many teens in state custody are denied access to quality health care and other services to help them make the transition to young adulthood and self-sufficiency. In the first phase of the previously cited study, Westat determined that nearly half (40 percent) of the sample fos-

ter care population (34,600) did not receive "some [sic] type of independent living service training" before exiting foster care, 69 percent had not participated in an independent living program, and 64 percent had not received skills training relevant to health.³⁵ Although the study did not attempt to examine the comprehensiveness or quality of identified services and programs, it did find that skills training in specific areas could make a positive difference in outcomes, such as obtaining health care and employment.³⁶

Similarly the earlier noted Wisconsin study discovered that "only a minority of young adults reported that they received concrete assistance in preparing for a variety of life skills prior to discharge."³⁷ Only 18 percent received job training, 12 percent received help in obtaining housing, 15 percent had assistance in obtaining personal health records, 11 percent had help in getting health insurance, and 11 percent received help in obtaining public assistance.³⁸ Moreover, only 46 percent of youths stated that they had at least \$250 in their possession at the time of their discharge from foster care.³⁹ Voicing their concerns regarding health care, including preventive services, for these young people, this study asserted that "[t]he long-term effect of accessibility of such care may contribute to more serious difficulties if ongoing problems remain untreated and new ones go undetected."⁴⁰

³³ FAMILIES USA, ONE STEP FORWARD, ONE STEP BACK: CHILDREN'S HEALTH COVERAGE AFTER CHIP AND WELFARE REFORM (1999) (available from Families USA, Washington, D.C.).

³⁴ JOCELYN GUYER ET AL., MISSED OPPORTUNITIES: DECLINING MEDICAID ENROLLMENT UNDERMINES THE NATION'S PROGRESS IN INSURING LOW-INCOME CHILDREN (1999) (available from Center on Budget and Policy Priorities, Washington, D.C.).

³⁵ Cook et al., *supra* note 12, at vi-vii.

³⁶ COOK, *supra* note 22, at 5-4. See also Ronna J. Cook, *Are We Helping Foster Care Youth Prepare for Their Future?* 2 CHILD WELFARE RES. REV. 201 (1997); Edmund V. Mech et al., *Life Skills Knowledge: A Survey of Foster Adolescents in Three Placement Settings*, 16 CHILDREN & YOUTH SERVS. REV. 181 (1994); *Challenges Confronting Children and Older Children Leaving Foster Care: Hearing Before the Subcomm. On Human Resources of the House Ways and Means Committee*, 106th Cong. (1999) (testimony of Child Welfare League of America) <www.igc.apc.org/cwla/publicpolicy/independentlivingtestimony.html>.

³⁷ Courtney & Piliavin, *supra* note 25, at 4-5.

³⁸ *Id.* at 5.

³⁹ *Id.* at 6.

⁴⁰ *Id.* at 15.

C. Need for Comprehensive Health Services

Adolescents leaving foster care have high rates of numerous physical and mental health problems, often higher than their counterparts in the general population. Therefore, they should have access to a wide range of health care services, including

- comprehensive health assessments and general dental examinations;
- general preventive services (e.g., nutrition and exercise counseling; anticipatory guidance);
- teen pregnancy prevention and family planning services;
- preventive services for HIV or AIDS and other sexually transmitted diseases;
- other reproductive health care;
- mental health and substance abuse services;
- treatment for acute and chronic health problems; and
- case management.

Unfortunately serious barriers impede former foster youth's access to these health care services as well as to transitional living services that promote health and well-being. Current barriers include

- ineligibility for insurance programs such as Medicaid and State Children's Health Insurance Programs;
- lack of information about programs and health care for which they might be eligible;
- lack of knowledge concerning how to access the services that might be available to them; and

- ineligibility for or limitations on services in categorical health programs (e.g., mental health, substance abuse, sexually transmitted diseases, HIV) that would meet their needs.

While all of these factors are important, the availability of free or affordable health insurance coverage could make a critical difference for many of these youth. As Terry Harrak, the former foster youth, asserted at the Senate subcommittee hearing on the Foster Care Independence Act, "that was another big issue for me when I aged out of foster care, . . . Medicaid. The foster care system provided me with financial support and health insurance. When I left foster care, all of that stopped."⁴¹

III. Health Insurance Coverage

Health insurance coverage is a key element in access to health care for these young people. Studies have found that health insurance coverage can make a difference both in access to health care and in health outcomes. For example, individuals without insurance are four times more likely to postpone or forgo needed care.⁴² They also experience delayed diagnoses and later hospital admissions for serious illness as well as higher mortality rates compared to the general population.⁴³ The young people who are aging out of foster care fall into the group—18 to 24 years old—that is uninsured at the highest rate among all age groups.⁴⁴

Medicaid coverage, in particular, has the potential to be especially important for youth making the transition out of foster care because of the breadth of the Medicaid benefit package; this could be helpful in addressing their multiple and often serious health problems. Specifically Medicaid includes the Early and Periodic

⁴¹ Statement of Terry Harrak, *supra* note 2, at 17.

⁴² See, e.g., Alliance for Health Reform, *Health Coverage: How Much Does Insurance Matter?* (May 2000) (visited May 12, 2000) <www.allhealth.org/pub/pdf/05-00_HowMuch.pdf> (citing numerous studies).

⁴³ *Id.*

⁴⁴ In 1998 30 percent of all individuals, 18–24, were without health insurance, and 46.7 percent of individuals in that age group living below the federal poverty level were uninsured. U.S. Census Bureau, *Health Insurance Coverage: Consumer Income, 1998* CURRENT POPULATION REPORTS 3, tbl. 1 (Oct. 1998).

Screening, Diagnosis, and Treatment (EPSDT) requirements for Medicaid recipients who are under 21.⁴⁵ States are required to make available to these children and adolescents periodic comprehensive assessments of their health, inter-periodic health screens, and follow-up diagnosis and treatment.⁴⁶ All federally reimbursable benefits must be made available through EPSDT whether or not a state has included the benefits in its state title XIX plan for adults.⁴⁷

As explained below, however, many youth leaving the foster care system have not been eligible for Medicaid. Although most states provide Medicaid coverage for children and adolescents while they are in foster care, that eligibility often does not extend beyond the time when they leave state custody. Although younger children and adolescents who leave foster care might be able to qualify more easily for Medicaid or the new State Children's Health Insurance Program, those who age out of the system at 18 face far more limited choices.

IV. Medicaid Eligibility Prior to the Act for Youth Leaving Foster Care

In most states children are eligible for Medicaid while they are in foster care, although their eligibility is based on a

patchwork of coverage that derives from several different mandatory and optional eligibility categories.⁴⁸ Briefly children and youth who are eligible for foster care maintenance payments under title IV-E of the Social Security Act are automatically eligible for Medicaid. Those without this IV-E "linkage" are also often eligible on another basis, depending on decisions that have been made by their states. For example, foster children and youth who are not IV-E eligible may fit into another mandatory Medicaid eligibility category, such as the phased-in expansion of Medicaid eligibility for adolescents who are under 19 and born after September 30, 1983, and whose family incomes are less than or equal to 100 percent of the federal poverty level.⁴⁹ Alternatively states have the option of providing Medicaid coverage for foster children and youth who fit within one of many other optional Medicaid eligibility categories.⁵⁰ The net result has been that, in the majority of states, most foster children (in either federally assisted or state-supported foster care) have been eligible for Medicaid.

For young people who are aging out of foster care at 18, however, the picture has been quite different.⁵¹ Before the enactment of the Foster Care Independ-

⁴⁵ 42 U.S.C. § 1396a(a)(10) & (43), 1396d(a)(4)(B), 1396d(r); 42 C.F.R. § 441.50-441.62. See also 58 Fed. Reg. 51288 (Oct. 1, 1993) (proposed regulations); HEALTH CARE FIN. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., STATE MEDICAID MANUAL, pt. 5, §§ 5010-60 (visited May 30, 1999) <www.hcfa.gov/pubforms/pub45pdf/mnn5t.pdf>. For an extensive discussion of the requirements of the Medicaid program, see JANE PERKINS ET AL., AN ADVOCATE'S GUIDE TO THE MEDICAID PROGRAM (1993) [hereinafter MEDICAID GUIDE] (available from the National Health Law Program, Los Angeles, Cal.). A new edition of the guide will be released in 2000.

⁴⁶ 42 U.S.C. § 1396d(r)(1)-(5).

⁴⁷ *Id.* § 1396d(r)(5).

⁴⁸ For a more detailed discussion of foster care children's eligibility for Medicaid, see Abigail English & Madelyn DeWoody Freundlich, *Medicaid: A Key to Health Care for Foster Children and Adopted Children with Special Needs*, 31 CLEARINGHOUSE REV. 109 (July-Aug. 1997).

⁴⁹ 42 U.S.C. § 1396a(l)(1)(D).

⁵⁰ For a detailed discussion of mandatory and optional Medicaid eligibility categories through which adolescents may be able to qualify, see ABIGAIL ENGLISH ET AL., ADOLESCENTS IN PUBLIC HEALTH INSURANCE PROGRAMS: MEDICAID AND CHIP 39-41(1999) [hereinafter ADOLESCENTS IN PUBLIC HEALTH INSURANCE PROGRAMS] (available from the Center for Adolescent Health & the Law, Chapel Hill, N.C.).

⁵¹ Some states have chosen to provide health coverage through Medicaid or totally state-funded assistance for young people who remain in foster care beyond age 18. See, e.g., FREQUENTLY ASKED QUESTIONS, *supra* note 4, at 23. See also ENGLISH & FREUNDLICH, *supra* note 48.

ence Act, there was neither a mandatory nor an optional Medicaid eligibility category specifically for youth making the transition out of foster care, so these young people could qualify, if at all, only under another eligibility category, essentially unrelated to their former status in foster care. This meant that their options generally were quite limited: they might be able to establish Medicaid eligibility based on one or more of the following:

- eligibility for welfare cash assistance benefits (although this option became more complicated after 1996 when the long-standing automatic linkage between Medicaid eligibility and welfare cash assistance was severed);
- eligibility for Supplemental Security Income benefits (although this option is limited to individuals with severe disabilities);
- pregnancy and income below the percentage of the federal poverty level established for pregnant women in their state (although this eligibility would usually end 60 days postpartum); or
- income below the percentage of poverty established for adolescents according to the mandated phase-in of Medicaid coverage for poverty-level adolescents or any acceleration of the phase-in (although this would usually end at 19 for youth who are not pregnant or disabled).⁵²

Since states have begun to implement the new State Children's Health Insurance Program, some youth who are making the transition out of foster care and cannot qualify for Medicaid may be eligible

for a state-designed non-Medicaid Children's Health Insurance Program if their income is below the percentage of the federal poverty level established by their state for older adolescents, although this eligibility would end at 19.⁵³

Merely listing these alternatives serves to illustrate how complex it would be for a former foster youth to determine eligibility for Medicaid or other publicly funded health insurance. Moreover, child welfare case workers and even Medicaid eligibility workers are often unfamiliar with the relevant eligibility categories and thus are unlikely to advise youth about the Medicaid coverage options available to them. Fortunately the possibility now exists for states to simplify and thereby improve the health insurance situation of youth aging out of foster care.

V. Medicaid Expansion Option in the Act

The Foster Care Independence Act gives states the option of making Medicaid coverage available to youth who are aging out of the foster care system. The Act creates a new optional Medicaid eligibility group: "independent foster care adolescents . . . or any . . . reasonable categories of such adolescents specified by the State."⁵⁴ A version introduced in the Senate would have conditioned a state's receipt of new monies appropriated in the Act on the state's willingness to extend Medicaid eligibility to youth aging out of foster care.⁵⁵ The version that was ultimately enacted leaves the decision entirely to the discretion of the states, although the Health Care Financing Administration has urged states "to elect this new option to ensure that children

⁵² For tables setting forth a more nearly complete list of the mandatory and optional Medicaid eligibility categories that may be used to cover adolescents, see ADOLESCENTS IN PUBLIC HEALTH INSURANCE PROGRAMS, *supra* note 50, at 40–41, tbls. 7–8.

⁵³ See ADOLESCENTS IN PUBLIC HEALTH INSURANCE PROGRAMS, *supra* note 50, at 39–43.

⁵⁴ Foster Care Independence Act § 121(a), 113 Stat. 1829, *amending* 42 U.S.C. § 1396a(a)(10)(A)(ii).

⁵⁵ S. 1327, 106th Cong. 1st Sess., § 121 (1999). The Senate version was introduced by Sen. John Chafee on July 1, 1999. The bill was referred to the Senate Committee on Finance. A hearing on the Medicaid provisions was held on October 13, 1999 (*see supra* note 2), but the bill was not reported out of committee. After the death of Senator Chafee in late 1999, Congress moved quickly to enact H.R. 3443, the House version of the Foster Care Independence Act. The failure to condition a state's receipt of increased Act funds on the state's willingness to extend Medicaid benefits was one of the losses when S. 1327 was not enacted.

aging out of foster care have the health care that they need.”⁵⁶ Congress also included in the Act a “Sense of the Congress” provision making clear that “it is the sense of the Congress that States should provide medical assistance under the State plan approved under title XIX of the Social Security Act to 18-, 19-, and 20-year-olds who have been emancipated from foster care.”⁵⁷

A. Definition of Independent Foster Care Adolescent

An “independent foster care adolescent” is defined as an individual

- (A) who is under 21 years of age;
- (B) who, on the individual’s 18th birthday, was in foster care under the responsibility of a State; and
- (C) whose assets, resources, and income do not exceed such levels (if any) as the state may establish . . . consistent with the levels (if any) [applied by the state under Section 1931(b) of the Social Security Act].⁵⁸

States may choose to cover all “independent foster care adolescents” without restriction. If they do so, there would be only two criteria for determining eligibility: (1) Is the young person under 21 years of age? (2) Was the young person in foster care under the responsibility of a state on the person’s 18th birthday?

B. State Flexibility to Limit Eligibility

Though not required to do so, states are permitted to limit eligibility to narrower groups of young people. Specifically a state may limit eligibility to any “reasonable categories” of independent foster care adolescents.⁵⁹ For example, a state might limit eligibility by age, granting eligibility only to those under 20 or 19 rather than 21.⁶⁰ The Foster Care Independence Act explicitly allows a state to limit coverage to young people who before their 18th birthdays were receiving foster care maintenance payments or independent living services under title IV-E of the Social Security Act.⁶¹ Also, a state may limit eligibility by establishing an income, resource, or asset test.⁶² If it does so, however, the test may not be any more restrictive than the levels used for low-income families with children who are eligible under section 1931(b) of the Social Security Act.⁶³ Section 1931(b) requires that states grant Medicaid eligibility to children and families who would have qualified for Aid to Families with Dependent Children under the rules in place in their state on July 16, 1996.⁶⁴

C. Scope of Benefits

If a state elects to implement the Medicaid expansion option in the Foster Care Independence Act, youth covered under the option are eligible for the full range of Medicaid benefits. These include all mandatory and optional Medicaid ser-

⁵⁶ Letter from Timothy M. Westmoreland, Director, Center for Medicaid and State Operations, Health Care Financing Administration, U.S. Department of Health and Human Services, to State Medicaid Directors (Dec. 14, 1999) [hereinafter State Medicaid Director Letter].

⁵⁷ Foster Care Independence Act § 101(e), 113 Stat. 1822, 1829.

⁵⁸ *Id.* § 121(a)(2), (c)(5), 113 Stat. 1822, 1829, 1830, adding a new subsection 42 U.S.C. § 1396d(v)(1).

⁵⁹ *Id.* § 121(a)(1)(C), 113 Stat. 1822, 1829, codified at 42 U.S.C. § 1396a(a)(10)(A)(ii)(XV). The term “foster care” is not defined in the Act but should be interpreted broadly to include placements in foster family homes, group homes, residential treatment centers, and other settings.

⁶⁰ State Medicaid Director Letter, *supra* note 56.

⁶¹ Foster Care Independence Act, § 121(a)(3), 113 Stat. 1822, 1830, codified at 42 U.S.C. § 1396d(v)(3).

⁶² *Id.* § 121(a)(2), 113 Stat. 1822, 1830, codified at 42 U.S.C. §§ 1396d(v)(1)(C), (v)(2).

⁶³ *Id.*

⁶⁴ 42 U.S.C. § 1396u-1, 1396a(a)(10)(A)(i)(I). This provision was intended to protect children and families against the loss of Medicaid benefits that could result from the severing of the automatic linkage between cash welfare assistance and Medicaid eligibility—a severance that occurred in the 1996 federal welfare law, the Personal Responsibility and Work Opportunity Reconciliation Act.

vices, including EPSDT.⁶⁵ This means that former foster youth who enroll in Medicaid should be able to obtain any preventive health services, family planning services, and other reproductive health care, mental health, and substance abuse services that are federally reimbursable under Medicaid.⁶⁶

D. Federal Role

The Health Care Financing Administration in the U.S. Department of Health and Human Services is the federal agency responsible for implementing the Foster Care Independence Act's Medicaid expansion option. On December 14, 1999, when the Act was signed into law, the Health Care Financing Administration sent out a "Dear State Medicaid Director" letter informing its regional offices and state Medicaid agencies about the new Act. The letter's purpose is to "highlight how [the Act] gives [states] the flexibility to provide much needed health coverage to foster children as they make their transition to independence."⁶⁷ It acknowledges that the incidence of homelessness, substance abuse, and pregnancy can be high in this population, that clearly they continue to need access to medical care, and that on their 18th or 19th birthdays many lose the Medicaid coverage that protected them as foster children.⁶⁸

E. State Implementation

In order to take advantage of the Medicaid expansion option in the Foster

Care Independence Act, a state must submit to the Health Care Financing Administration an amendment to its state Medicaid plan under title XIX of the Social Security Act.⁶⁹ Such an amendment may be submitted at any time.⁷⁰ In view of the

If a state elects to implement the Act's Medicaid expansion option, youth covered under the option are eligible for the full range of Medicaid benefits.

Health Care Financing Administration's explicit encouragement to use the expansion option, plan amendments designed to do so are likely to be approved as long as they meet the criteria specified in the Act.⁷¹

States electing the option are required to provide matching funds. The rate at which the federal government will provide funds is the regular state Medicaid matching rate or "medical assistance percentage." For fiscal year 2000, which began on the effective date of the Medicaid expansion provision of the Foster Care Independence Act, the federal Medicaid matching rates vary between 50 percent and 77 percent.⁷² States may provide their required matching funds from a variety of sources.⁷³

How many states will elect to adopt the Medicaid expansion option is not yet known. As of May 2000, a small number of states had already introduced legislation to implement the option.⁷⁴ These include

⁶⁵ See *supra* text accompanying notes 45–47.

⁶⁶ For further discussion of the legal framework for Medicaid benefits that adolescents need, see ADOLESCENTS IN PUBLIC HEALTH INSURANCE PROGRAMS, *supra* note 50, at 60–64.

⁶⁷ State Medicaid Director Letter, *supra* note 56.

⁶⁸ *Id.*

⁶⁹ *Id.* See also 42 C.F.R. § 430.10–430.25 (1997) (setting forth the state plan submission process).

⁷⁰ *Id.*

⁷¹ State Medicaid Director Letter, *supra* note 56.

⁷² 64 Fed. Reg. 1805–8 (Jan. 12, 1999).

⁷³ See 42 C.F.R. § 433.50–433.74 (setting forth the permissible sources of state Medicaid matching funds and related requirements).

⁷⁴ Responses to preliminary telephone and e-mail surveys conducted by the Child Welfare League of America, the National Resource Center for Youth Services, and the Center for Adolescent Health & the Law indicate that a significant number of states are at least considering implementation of the Medicaid expansion option, although many of them are awaiting cost estimates before moving forward with implementation.

Arizona, California, and Washington.⁷⁵ Arizona, which has already enacted its legislation, elected to cover all otherwise eligible former foster youth with incomes under 200 percent of the federal poverty level.⁷⁶ The California bill, which is pending, appears to make former foster youth eligible for Medicaid on the same basis as youth in foster care. The California bill contains a legislative finding that the Foster Care Independence Act “allows states to expand medicaid [sic] coverage to former foster youth until their 21st birthday, and allows states to eliminate the existing income and resource standards for former foster youth.”⁷⁷ The bill also declares that “[i]t is the intent of the Legislature . . . to provide former foster youth with basic medical coverage dur-

ing the critical transition from foster care to adulthood and self-sufficiency.”⁷⁸ The Washington legislation would provide eligibility for the broadest group of former foster youth allowed by the Act.⁷⁹

F. Effective Date

The Act specifies that the effective date of the Medicaid expansion option is October 1, 1999.⁸⁰ This means that a state may seek federal matching funds for services provided beginning on or after the effective date as long as the state has approval from the Health Care Financing Administration for a Medicaid state plan amendment under title XIX of the Social Security Act.⁸¹ As long as the state is prepared to provide the matching funds and acts quickly to implement the expansion,

⁷⁵ H.B. 2400, 44th Leg. 2d Sess., § 4 (Ariz. 2000) (enacted), *amending* ARIZ. REV. STAT. § 36-2901(4)(b) to add a new subsection (III) (defining persons eligible for Medicaid to include any person who is “under twenty-one years of age, who was in the custody of the Department of Economic Security pursuant to Title 8, Chapter 5 or 10 when the person became eighteen years of age and who has an income that does not exceed two hundred percent of the federal poverty guidelines as updated annually in the Federal Register by the United States Department of Health and Human Services”); S.B. 147, 1999–2000 Sess., § 2 (Cal. 1999) (pending), proposing to add new CAL. WELF. & INST. CODE § 14005.28 (providing that the State Department of Health Services “shall . . . amend the state Medicaid plan to extend Medi-Cal benefits to foster youth 20 years of age of age and under” and providing that any person “who was in foster care immediately prior to his or her 18th birthday shall remain eligible for Medi-Cal benefits as if he or she were in foster care commencing on [his or] her 18th birthday until his or her 21st birthday, whether or not he or she emancipates from foster care during that time”); H.B. 2984, 56th Leg. 2d Sess., § 1 (Wash. 1999) (pending), proposing to amend WASH. REV. CODE § 74.09.510 to add a new subsection (9) (adding a Medicaid eligibility category for “persons under the age of twenty-one, who, on the person’s eighteenth birthday, were in foster care under the responsibility of a state”).

⁷⁶ ARIZ. REV. STAT. § 36-2901(4)(b)(III).

⁷⁷ S.B. 147, 1999–2000 Sess., § 1(a)(5) (Cal. 1999) (pending).

⁷⁸ S.B. 147, 1999–2000 Sess., § 1(b) (Cal. 1999) (pending).

⁷⁹ H.B. 2984, 56th Leg. 2d Sess., § 1 (Wash. 1999). It also appears to provide eligibility regardless of the state in which the youth had been in foster care. *Id.*

⁸⁰ Foster Care Independence Act § 121(b), 113 Stat. 1822, 1830 (specifying that “[t]he amendments made by subsection [121](a) apply to medical assistance for items and services furnished on or after October 1, 1999”).

⁸¹ The Children’s Bureau in the Administration on Children, Youth, and Families has instructed the states that, with respect to funds under the Chafee Foster Care Independence Program, once a state’s application has been approved the state may obligate and expend funds retroactively. ACYF-CB-PI-00-04, *supra* note 3, at 5. The program instruction does not address the issue of retroactive expenditures under the Medicaid expansion option. The Medicaid option is administered by the Health Care Financing Administration, which has not yet issued technical guidance on this issue. However, from the effective date specified in the statute, states apparently may obligate and expend funds retroactively under the Medicaid expansion option as well. However, Medicaid regulations specify that the effective date of a title XIX Medicaid state plan amendment making additional groups eligible for services provided under the approved plan may not be earlier than the first day of the quarter in which an approvable plan is submitted to the Health Care Financing Administration regional office. 42 C.F.R. § 430.20(a)(2), (b)(1).

it could receive federal matching funds for Medicaid services provided to former foster youth under the expansion option for all or most of fiscal year 2000. However, youth will not begin to benefit until states submit title XIX Medicaid state plan amendments.

G. Number of Potentially Eligible Youth

In implementation—reaching as many potentially eligible young people as efficiently as possible—the size of the total pool is important to know. The Congressional Budget Office estimated that in 1998 there were 65,000 people who were 18, 19, or 20 years old, had been in foster care on their 18th birthdays, and were no longer receiving foster care services.⁸² This number represents the total pool of youth potentially eligible for Medicaid under the Foster Care Independence Act's expansion option if all states were to elect the option and establish eligibility as broadly as they are permitted to do under the Act. Admittedly some of these youth would already have been eligible for Medicaid under another mandatory or optional category.⁸³ However, the Act does not limit the application of the new expansion option to youth who were not previously eligible for Medicaid. Thus, for purposes of calculat-

ing the increased costs to the federal government and the states, we need to estimate the number of young people who would be newly eligible for and would enroll in Medicaid. The Congressional Budget Office estimates this number to be 24,000 in 2004.⁸⁴

VI. Implementation

Policymakers and advocates can work in numerous ways to implement the Foster Care Independence Act to improve access to health care for youth leaving foster care. For example, in its state plan under the Chafee Foster Care Independence Program, a state could, and arguably should, address the health care needs of this population.⁸⁵ However, because the primary mechanism offered by the Act is the Medicaid expansion option, policymakers and advocates should devote particular attention to making sure that this mechanism works as effectively as possible.

A. What States Can Do

Specifically each of the following ten actions by states would help to ensure that the maximum number of former foster care youth have access to essential health care:

- Every state should elect to implement the Medicaid expansion option contained in the Foster Care Independence Act for

⁸² CONGRESSIONAL BUDGET OFFICE, COST ESTIMATE: H.R. 1802, FOSTER CARE INDEPENDENCE ACT OF 1999, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON WAYS AND MEANS ON MAY 26, 1999 (visited Oct. 11, 1999) <www.cbo.gov/showdoc.cfm?index=1343&sequence=0&from=6>. The budget office estimates that this number will rise to 80,000 by 2004. *Id.*

⁸³ *Id.*

⁸⁴ The Congressional Budget Office estimates that by 2004, assuming that 85 percent of former foster children will be eligible under the new option (with not all states electing to implement the option), about 68,000 individuals will be eligible; of those approximately 51,000 can be expected to enroll. *Id.* This would represent a net increase in Medicaid enrollment of about 24,000. *Id.* The budget office estimates that the added cost to the federal government for these new enrollees will be about \$65 million in 2004. *Id.*

⁸⁵ E.g., state plans need to include how states will “use objective criteria for determining eligibility for benefits and services under the programs, and for ensuring fair and equitable treatment of benefit recipients.” Foster Care Independence Act § 101(b), 113 Stat. 1822, 1825, 42 U.S.C. § 677(b)(2)(E). This should arguably include a reference to determining eligibility for Medicaid. States also could choose to include in their independent living programs health education services, which could instruct young people on how to access health care. Instruction and counseling on how to access health care arguably fall within the scope of a state's required certification in its state plan that foster parents and others working with youth will be trained on how to “understand and address the issues confronting adolescents preparing for independent living. . . .” *Id.* § 101 (b), 113 Stat. 1822, 1825, 42 U.S.C. § 677(b)(3)(D). Instruction and counseling may also fall within the scope of the required certification that the state will “make every effort to coordinate the State programs receiving funds provided . . . with other Federal and State programs for youth.” *Id.* § 101(b), 113 Stat. 1822, 1825, 42 U.S.C. § 677(b)(3)(F).

all youth who are under 21 and were in foster care under the responsibility of the state on their 18th birthdays to ensure that they have health insurance coverage and access to the full range of Medicaid benefits, including EPSDT.

- Each state that implements the Medicaid expansion option should do so for the broadest allowable group of former foster youth and should not impose restrictions based on age, income, resources, or any other factors not required by the statute.

- State child welfare agencies and state Medicaid agencies together should develop mechanisms guaranteeing that young people leaving state custody are informed automatically of their right to receive ongoing Medicaid coverage after they exit foster care.

- State child welfare agencies and state Medicaid agencies should work closely with one another and with other agencies and organizations in the community to reach out to former foster youth who were not enrolled in Medicaid upon exiting foster care.

- State Medicaid agencies should develop simplified application forms to enable former foster youth to enroll on a virtually automatic basis when they leave foster care.⁸⁶

- States should train case workers, foster parents, and young people who are in foster care or receiving independent living services about the eligibility of current and former foster youth to receive Medicaid benefits and the steps they can follow to enroll.

- States should inform and train case workers, foster parents, and current and former foster youth who are enrolled in Medicaid about the services to which they are entitled and how they can use the services.⁸⁷

- States that have implemented Medicaid managed care programs should allow the maximum flexibility for beneficiaries who are former foster youth to select health care providers with training, interest, and experience in caring for this population and should ensure that such providers are included in the Medicaid managed care plans' provider networks.

- States should ensure that former foster youth who are enrolled in Medicaid are exempt, to the maximum extent permitted by law, from any payment of premiums, deductibles, coinsurance, or copayments.

- States that implement the Medicaid expansion option should allow former foster youth who live in the state to enroll regardless of the state in which they were placed in foster care.

B. What Advocates Can Do

A broad range of advocates for children and youth can promote access to health care for youth leaving foster care. Each of the following actions by advocates could help encourage states to implement the Foster Care Independence Act's Medicaid expansion option as fully as possible and could promote access to health care for former foster youth in other important ways:

- Advocates should encourage state Medicaid agencies and state child wel-

⁸⁶ E.g., if a state elects to provide Medicaid coverage for the entire pool of former foster youth that it is permitted to cover under the federal statute, possibly the only documentation that would be required for eligibility would be a birth certificate and a certificate from a state that the youth had been in foster care on the youth's 18th birthday.

⁸⁷ See Patricia Ryan et al., *The Role of Foster Parents in Helping Young People Develop Emancipation Skills*, 67 CHILD WELFARE 563 (Nov.–Dec. 1988) (discussing development of educational materials for foster parents to enable them to help a youth transition to adulthood); Wendy F. Auslander et al., *HIV Prevention for Youths in Independent Living Programs: Expanding Life Options*, 77 CHILD WELFARE 208 (Mar.–Apr. 1998) (“In recognition of the influence of the social environment on behavioral change, adults significant to these youths [sic] must take the lead in reinforcing HIV prevention messages. For youths [sic] in out-of-home care, these adults may include their workers or foster parents, and/or staff members of residential programs.”).

fare agencies to take each of the ten actions suggested above.

- Advocates should work to educate members of their state legislatures about the health status of former foster youth, their health care needs, and the options available under the Act's Medicaid expansion option for addressing those needs.

- Advocates should participate in the development of their states' plans and applications for funds under the Chafee Foster Care Independence Program.

- Advocates should work to educate a broad range of health care providers, as well as youth-serving agencies, community-based organizations, and courts about the health status of former foster youth, their health care needs, and the options available under the Medicaid expansion option for addressing those needs.

- Advocates should work directly with former foster youth themselves to educate them about their rights with respect to health care access, to encourage them to enroll in Medicaid and make full use of the services available to them, and to support them in seeking out forums (e.g., development of their own independent living plans, child welfare advisory groups) in which their voices can be heard on the issues to be addressed.⁸⁸

- Advocates who represent youth in foster care should make sure, after consultation with their clients, that custody of their clients by the child welfare agency is not prematurely terminated because termination of custody before their 18th birthdays may deprive them of eligibility

for Medicaid benefits under the Medicaid expansion option.⁸⁹

- Advocates should work to ensure that their juvenile and family courts are authorized to maintain jurisdiction over the cases of youth leaving foster care because judges can be instrumental in monitoring the provision of health and other services to youth; in those states in which court jurisdiction terminates at age 18, advocates should support the enactment of legislation designed to permit the extension of court jurisdiction to youth until they are 21.⁹⁰

VII. Conclusion

The Foster Care Independence Act offers a new opportunity to meet the health care needs of young people who are aging out of the foster care system. Young people in foster care have multiple, complex physical and mental health problems for which they require access to

State child welfare agencies and state Medicaid agencies together should develop mechanisms guaranteeing that young people leaving state custody are informed automatically of their right to receive ongoing Medicaid coverage after they exit foster care.

a broad range of health services. Medicaid offers a broad benefit package that can help meet those needs. Although most young people are eligible for Medi-

⁸⁸ On independent living plans, the Foster Care Independence Act § 101 (b), 113 Stat. 1822, 1826, *codified at* 42 U.S.C. § 677(b)(3)(H), provides that the chief executive officer certify in the state plan implementing the Act "that the State will ensure that adolescents participating in the program under this section participate directly in designing their own program activities that prepare them for independent living and that the adolescents accept personal responsibility for living up to their part of the program." *See also* Amy Clay, *Assisting a Youth in Transition*, 18 ABA CHILD L. PRAC. 65 (July 1999) (presenting a youth's view of her experiences with independent living classes and foster care).

⁸⁹ For a discussion of litigation strategies relevant to representing youth moving out of foster care systems, see also Kathi Grasso, *Litigating the Independent Living Case*, 18 ABA CHILD L. PRAC. 65 (July 1999) (note that this article was written before the enactment of the Foster Care Independence Act).

⁹⁰ *See also id.*, at 71 (discussing the importance of maintaining court jurisdiction in accessing independent living services).

caid while they are in foster care, many lose eligibility when they reach age 18 and leave state custody.

The Act provides an option for states to extend Medicaid eligibility for young people who are under 21 and who on their 18th birthdays were in foster care under the custody of the state. Many states have not yet decided whether to implement this option. In addition to

implementing this option, states can take many steps through their child welfare agencies and Medicaid agencies to ensure that young people leaving foster care enroll in Medicaid and receive the services to which they are entitled. Advocates also can play a critical role in ensuring that this vulnerable population has access to essential health care.

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